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AmeriCorps CARE CHILD CARE PROVIDER INFORMATION AND REGISTRATION FORM
PLEASE PRINT CLEARLY * TO BE COMPLETED BY CHILD CARE PROVIDER ONLY *

Provider's Name _____ Date of Birth _____/_____/_____
(As it will appear on checks and on coupons):

Provider's Mailing Address:

_____ _____ _____ _____
Street Name and Number City State Zip Code

Address where care is to be provided:

_____ _____ _____ _____
Street Name and Number City State Zip Code

In which county is care provided?: _____ Provider's telephone number (_____)_____-_____

If provider is unlicensed/unregulated: SSN #: _____-_____-_____ (**ATTACH A COPY OF SOCIAL SECURITY CARD)**
Or
If provider is licensed/regulated: Fed ID # _____-_____-_____ **(ATTACH A COPY OF LICENSE OR REGISTRATION)**

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Check as appropriate:

Type of Care: _____FDC (Family Day Care Home) _____ Center _____Group Home

Regulatory Status: _____ Unlicensed/Unregulated _____ Licensed/Regulated _____Exempt (i.e. family member, friend) **

Child Care License No. /Registration No. (If applicable): _____
Licensing Contact Name and Phone Number: _____ (_____) _____-_____

**YOU MUST MEET STATE GUIDELINES TO BE CONSIDERED LEGALLY EXEMPT; contact AMERICORPS CARE or your state licensing agency for more information.

Date Care Begins: _____/_____/_____ Date Care Ended (if applicable): _____/_____/_____

AmeriCorps Member's Name: _____

NAMES OF CHILDREN TO BE CARED FOR THROUGH AMERICORPS CARE

Name of Member's Child(ren) In Your Care	SSN (must be filled in)	Date of Birth	Gender (M/F)	Relationship to Provider
1.	- -			
2.	- -			
3.	- -			
4.	- -			

Name of Member's Child(ren) In Your Care	Period of Care (Check all that apply) SUN	MON	TUE	WED	THU	FRI	SAT	**Hours Children are in Care** From	To
1.									
2.									
3.									
4.									

To be completed by Family Day Care, Group Homes, and Unlicensed/Unregulated Individuals Only: Please list the total number of children in your care and relationship to you, if applicable. Total # of Children in Your Care: _____

Child's Name: **Relationship to Provider:**

_____ _____
_____ _____
_____ _____

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PROVIDER RESPONSIBILITIES AND CERTIFICATION

1. Provider will continue to meet all minimum requirements set by the state and agrees to comply with all AMERICORPS CARE policies necessary for reimbursement.
2. Provider will notify AMERICORPS CARE immediately when a child stops receiving care. It is understood that any parent must be given access to his/her child(ren) at any time during care hours.
3. Provider will mail the monthly coupon/attendance sheet **NO LATER THAN the first (1st) day** of the month following care or upon termination of care (if care stops before the end of the month). **PLEASE NOTE:** Reimbursement may be delayed if the childcare coupon is postmarked later than the 1st day of the month following care. In addition, 24-hour or overnight care **may not** be legal in all states.
4. Provider will not charge a higher fee for children of AMERICORPS Members than for the same service to the public. **NOTE: Failure to adhere to this policy will result in provider being required to refund overpayments and in cancellation of this and future payments from AMERICORPS CARE.**
5. **AMERICORPS CARE** will not pay additional fees for registration, late, transportation, meals, snacks, trips (ie., fieldtrips, etc.) or any other miscellaneous fees. Provider shall collect any such fees directly from the Member.
6. Provider agrees to repay **AMERICORPS CARE** any money received for which services were not provided.
7. Provider agrees to notify **AMERICORPS CARE** at least fifteen (15) calendar days before ending childcare services. **NOTE: In cases of emergency please notify AMERICORPS CARE immediately (1.800.570.4543).**

The Member has chosen you to provide childcare services. Prior to reimbursement, you must first provide all information requested on the front of this form, be determined a legal provider in your state, and the member must be determined and remain eligible to receive benefits through AMERICORPS CARE.

_____ _____/_____/_____

Provider Signature **Date**

AMERICORPS CARE RESPONSIBILITIES

1. AMERICORPS CARE is responsible for coordination of childcare payments and other related support services as necessary to the children and families served under this agreement.
2. AMERICORPS CARE will pay only pay **licensed and regulated** providers for federal holidays and school vacations. AMERICORPS CARE will also pay **licensed and regulated providers** for up to five sick/no-care days per month. Excessive absences may require formal documentation (i.e.., doctor's note).
3. AMERICORPS CARE will not pay more than one provider, for the same child (ren), for the same period of care.

PARENT RESPONSIBILITIES AND CERTIFICATION

I [the member] understand that:

1. Childcare benefits for which I am eligible are based on my income, family size, age of child(ren), the provider's location, and the type of child care I select and that if there are any changes to my situation**, I must make both my State Program Officer and AMERICORPS CARE aware of those changes**.
2. I agree to complete the necessary documents (i.e., childcare coupons) on a timely basis, to ensure the provider may receive timely reimbursement.
3. I agree to submit proof of my continued eligibility for this program when requested.
4. I agree to notify AMERICORPS CARE at least fifteen (15) calendar days before ending childcare services. In cases of emergency please notify AMERICORPS CARE immediately (1.800.570.4543).
5. I understand that the provider indicated on page 1 of this form must meet all state requirements to provide childcare services, and that AMERICORPS CARE is under no obligation to begin reimbursements before the provider has been determined legal.

I have read this agreement and understand that failure to comply with the terms of this agreement may result in the termination of my childcare benefits.

_____ _____/_____/_____

AMERICORPS Member's Signature **Date**

MEMBER: PLEASE FORWARD APPLICATION AND PROVIDER FORMS TO YOUR PROGRAM DIRECTOR FOR SIGNATURES

PROGRAM DIRECTOR CERTIFICATION

I certify that the Member requiring childcare services as per this agreement is a full-time AMERICORPS Member and is eligible for childcare benefits through AMERICORPS CARE. I authorize that funds designated for childcare be made available to AMERICORPS CARE for regular payment of services as described above.

_____ _____ ____/____/____

Program Director's Name **Program Director's Signature** **Date**

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PROVIDER RATES DISCLOSURE

Please complete ***all sections*** below. Mark "NA" in sections that do ***not*** apply to you.

Provider's Name (If licensed/registered, must indicate name as it appears on license/registration):							
Tax I.D. or Soc. Sec. #:							
License Number: Expiration Date: **COPY OF LIC/REG. MUST BE ATTACHED**							
Ages Served:							
Days of Operation:							
Hours of Operation:							

PROVIDER RATES

- The rates listed below are the true and correct rates that I charge *all* parents for the care of their child (ren).
- I understand that AmeriCorps CARE cannot pay me more than I charge private pay clients.
- I also understand that AmeriCorps CARE cannot pay me more than the maximum rate(s) as established by the Child Care & Development Fund for my state.
- The rate specified is the charge for normal provision of childcare services.
- I understand that I must notify AmeriCorps CARE at least 15 (fifteen) days prior to any rate change in order for the new rate to be honored.
- I understand that AmeriCorps CARE cannot pay fees or charges for registration, transportation, meals, late pick-up, early withdrawal, or any other miscellaneous fees or charges.
- I also understand that in any of the above cases, the parent is responsible for such fees and/or charges.
- I understand that program or policy violations will result in having to repay money to AmeriCorps CARE and/or suspension from future participation in the AmeriCorps CARE childcare subsidy program.

Please list the rates that you charge per child. The rates will still be negotiated by AmeriCorps CARE.

AGE GROUP	FULL TIME WEEKLY	PART TIME WEEKLY	*24 HOUR/ OVERNIGHT (DAILY)	*"SPECIAL NEEDS" WEEKLY
UNDER 2 ½				
2 ½ - SCHOOL AGE				
SCHOOL AGE - 12				

***Not reimbursable in all states.**

I hereby certify the above information is true and correct.

_____

Provider's Signature – (If licensed or registered, this must be signed by Owner or Authorized Agent of Owner)

Date: _____/_____/_____

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AMERICORPS CARE PROVIDER PROFILE
FOR **LICENSED/REGULATED** PROVIDERS **ONLY**

ANNUAL CLOSURE SCHEDULE
YEAR BEGINNING SEPTEMBER 20___

PROVIDER NAME AS IT APPEARS ON PROVIDER PROFILE:

_____

- AMERICORPS CARE reimburses licensed/regulated providers for up to 5 (five) "No Care" days per month, per child.
- AMERICORPS CARE reimburses licensed/regulated providers for all national holidays on which the childcare facility is closed.
- AMERICORPS CARE reimburses licensed/regulated providers for scheduled annual closures, with our prior approval.
- If closures are to be changed from the approved closure schedule, AMERICORPS CARE *must receive notice 15 days prior to the change.*

*** Please enter specific **date and day of week** the childcare facility is scheduled to be closed:

	DAY/DATE	DAY/DATE	DAY/DATE	DAY/DATE	DAY/DATE	DAY/DATE
September:						
October:						
November:						
December:						
January:						
February:						
March:						
April:						
May:						
June:						
July:						
August:						